



Public Health
England

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New psychoactive substances (NPS) in prisons

A toolkit for prison staff

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Who is this toolkit for?

The increasing use of NPS within secure environments is presenting prison-based staff with a significant set of new challenges. This toolkit supports custodial, healthcare and substance misuse staff by providing information about the extent of NPS use as we currently understand it and about the properties of the various categories of NPS, and by providing advice on how to manage the problem from a clinical, psychosocial and regime perspective.

**What do we
mean by NPS?**

What do we mean by NPS?

- NPS, also known as legal highs or research chemicals, continue to present a challenge to treatment services in the community and in prisons
- problematic terminology: often not new, legal or 'high' inducing
- significant variations across the country; regional/local subcultures and micro-cultures
- people may use them for experimental, recreational purposes or if they have become dependent on them
- shifting patterns of use due to variable purity and cost, along with perceptions of legal status and their desired or adverse effects

The law

The law

- **January 2015 – MoJ applies a range of measures to address NPS use in prisons**
www.gov.uk/government/news/new-crackdown-on-dangerous-legal-highs-in-prison
- **Serious Crime Act 2015 the new legislation makes it a crime to throw any object into a prison, including NPS**
www.legislation.gov.uk/ukpga/2015/9/pdfs/ukpga_20150009_en.pdf
- **Psychoactive Substances Bill 2015.**
Queen's speech "new legislation will... ban the new generation of psychoactive drugs"
www.gov.uk/government/collections/psychoactive-substances-bill-2015
- **local authorities, supported by the police, will continue to use a variety of trading standards and consumer legislation, along with measures to prevent antisocial behaviour and to protect public spaces, in order to address the problem in community settings**

Categories of NPS

Categories of NPS

- project NEPTUNE (March 2015) has been developed to improve clinical practice in managing harm resulting from club drugs and NPS use. It divides these drugs into four categories:

1. Synthetic

cannabinoids (SC)

include a large number of drugs, the best known and most widely used being Spice and Black Mamba

2. Depressants

include such drugs as GHB (gamma hydroxybutyrate), GBL (gamma butyrolactone) and ketamine, which has dissociative effects in addition to its depressant effects

3. Stimulants

include drugs like MDMA (3,4-methylene-dioxymethamphetamine), better known as ecstasy, and ecstasy variants such as PMA (paramethoxyamphetamine) and PMMA (paramethoxymethamphetamine)

4. Hallucinogens

include drugs such as LSD (lysergic acid diethylamide) and assorted tryptamines and phenethylamines

www.neptune-clinical-guidance.co.uk

The current evidence indicates that the majority of NPS circulating in the prison system are synthetic cannabinoids

Prevalence: anecdotal reports

Prevalence: anecdotal reports

- prison staff consistently express concern about high rates of SC use (usually Spice and Black Mamba), including by prisoners without a prior history of drug misuse
- Nick Hardwick, HM Chief Inspector of Prisons, stated in September 2015 that two-thirds of prisons reported having a “significant issue” with NPS in 2014-15 compared to one-third in 2013-14
- healthcare staff report a significant impact on their day-to-day workload as a consequence of dealing with the acute adverse effects of Spice

Prevalence: seizures

Prevalence: seizures

A recent response to a parliamentary question (209374) reported that seizures of Spice have increased from 15 in 2010 to 430 during the seven months from 1 January to 31 July 2014. During the same period, there were only 21 seizures of ketamine, mephedrone and benzylpiperazine combined

(see table below, www.gov.uk/government/news/new-crackdown-on-dangerous-legal-highs-in-prison)

	1 Jan 2010 to 31 Dec 2010	1 Jan 2011 to 31 Dec 2011	1 Jan 2012 to 31 Dec 2012	1 Jan 2013 to 31 Dec 2013	1 Jan 2014 to 31 July 2014
Mephedrone	0	0	0	3	2
BZP	0	1	0	0	0
Spice	15	86	133	262	430
Ketamine	1	3	5	2	4
Total	16	90	138	267	436

Prevalence: seizures (continued)

Conversely, positive tests for traditional cannabis fell by 59% (from 8.6% to 3.9% positive results) between 2003-04 and 2013-14

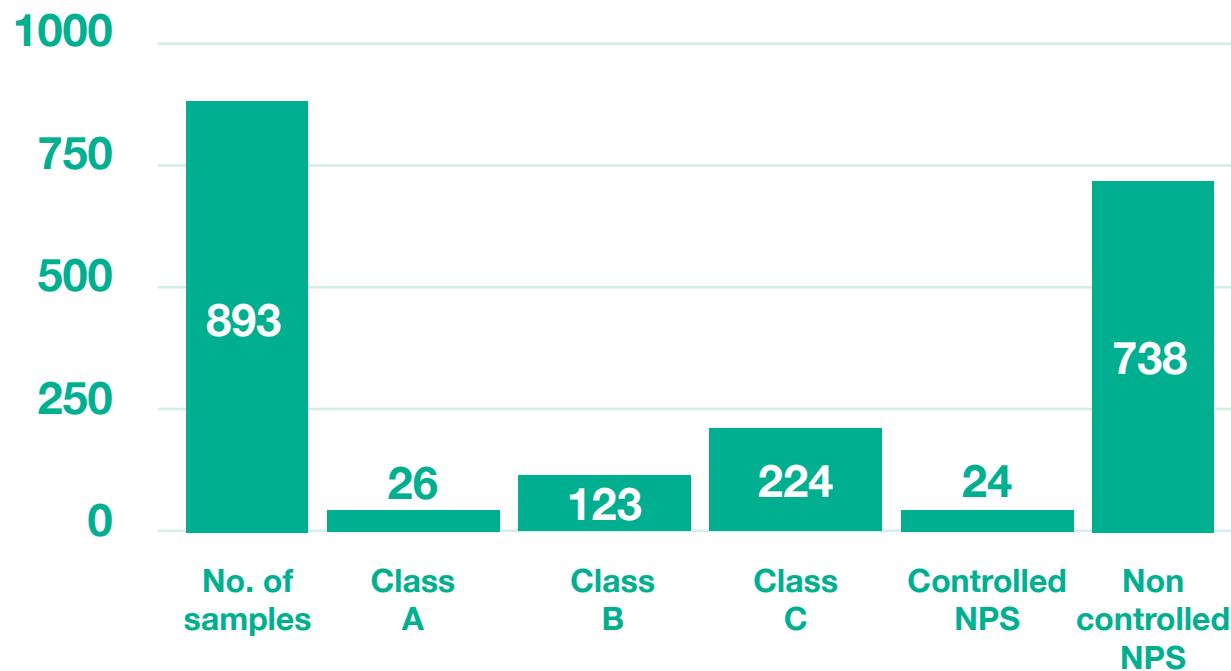
Centre for Social Justice 2015:

www.centreforsocialjustice.org.uk/UserStorage/pdf/Pdf%20reports/CSJJ3090_Drugs_in_Prison.pdf

As a result of increasing concerns around the availability and use of NPS in prisons, the Home Office Forensic Early Warning System (FEWS) has undertaken an analysis of seized inbound samples to identify the types of NPS being smuggled into prisons. Of the 893 samples analysed, 762 were found to be NPS. See table overpage

Prevalence: seizures (continued)

Samples of drugs seized being brought in to prison



www.gov.uk/government/uploads/system/uploads/attachment_data/file/461333/1280_EL_FEWS_Annual_Report_2015_WEB.pdf

Reasons for the popularity of NPS, particularly SC

Reasons for the popularity of NPS, particularly SC

- undetectable by conventional onsite testing, make time pass more quickly and easier to get hold of
- relative affordability, but emerging evidence that this may be changing
- the unpredictable effects of SC may be an attractive feature of these drugs to some prisoners who wish to experiment or be more adventurous with their drug use
- prior to the Ministry of Justice applying sanctions for NPS possession and use in January 2015, uncertainty in relation to their legal status may have contributed to the popularity of NPS among prisoners

Challenges for healthcare staff

Challenges for healthcare staff

- as with all illicit drug use in prison, the covert nature of NPS use, the unpredictable effects of the drugs and the delay in seeking medical help all combine to have a significant impact on healthcare staff
- the adverse effects of NPS in general are discussed in more detail at the end of the toolkit but, in view of the prevailing concerns about SC, we briefly consider some of their adverse effects in this part of the document
- some of the extreme effects of SC (convulsions, bizarre behaviour, temporary paralysis, rapid heart rate, aggression and psychosis) require an immediate response and may require transfer to hospital
- the adverse effects of SC use can be long lasting, and custody and healthcare staff may have to manage the consequences for months following the initial presentation
- some prisoners who use SC may not see themselves as having a problem with their use, so may be reluctant to engage with substance misuse teams or take measures to reduce or discontinue their use of the drugs, but they should be given every encouragement and support to do so

Challenges for the wider prison regime

Challenges for the wider prison regime

- the rapidly increasing prevalence of NPS in prisons is placing additional demands on prison and security staff resources in terms of supply disruption, searching and detection activities
- the need to restrain and control prisoners behaving abnormally or dangerously, or to transfer prisoners to hospital, or to manage long-term challenging or aggressive behaviour, clearly have implications for custodial staff within prisons
- Nick Hardwick, HM Chief Inspector of Prisons, stated in September 2015 that increased use of NPS in prisons would appear to be contributing to rising problems with debt, bullying and violence, and that evidence suggests organised crime groups are supplying NPS to prisons

Management of NPS in prisons

Management of NPS in prisons

- establishing accurate data on the prevalence, use and effects of NPS remains crucial to determining successful management of the problems associated with these drugs
- it is essential that every establishment has an integrated response, with custodial, health and psychosocial care staff taking a joint approach to managing all aspects of the problems associated with SC in prisons
- this integrated response is underpinned by a multimedia campaign directed at prisoners and visitors, describing the consequences and sanctions for possessing and using NPS
- the overriding principle is that staff should respond in a proportionate and relevant way to presenting behaviour or symptoms, irrespective of whether prisoners are suspected to be under the influence of NPS

Prison healthcare providers should follow existing PHE guidance that the appropriate response is to address symptoms rather than the specific drug

Where there are questions about prisoners' mental capacity when under the influence of NPS, staff should apply the principles set out in the NHS choices consent to treatment guidance

(www.nhs.uk/Conditions/Consent-to-treatment/Pages/Capacity.aspx)

Issues related to control and restraint are covered by PSO 1600 – Use of force

Management of NPS in prisons (continued)

- in general, no specific pharmacological treatments exist for the adverse effects of NPS, so symptom-directed supportive care will inform the safe and effective management of acute presentations, underpinned by advice from the National Poisons Information Service and its online toxicology database and telephone enquiry service TOXBASE
- the mainstay of longer-term treatment will be the appropriate clinical and psychosocial support as described in the Project NEPTUNE guidance document. So substance misuse services may need to adapt their current treatment practices in order to better address the needs of people using NPS
www.neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf

**Drugs: desired
effects, users,
adverse effects,
and managing acute
and chronic adverse
effects**

Synthetic cannabinoids

Note that while the evidence indicates SC account for the majority of NPS currently used in prisons, we recognise that the situation is fluid and subject to change and so have included information on the four categories of NPS and club drugs described in Project Neptune

Class B where classified

Street names

Annihilation
Amsterdam Gold
Spice
Black Mamba

More
information
online

Desired effects

Relaxation, euphoria, disinhibition, feeling energised, altered consciousness

Users/modes of use

Users: prisoners, workers subject to drug testing, students, graduates

Modes of use: smoked in joints or inhaled through a bong, rarely ingested or snorted

Adverse effects

Acute: convulsions, paralysis, psychosis, extreme bizarre behaviour, tachycardia, aggression

Without rapid urine or blood tests to confirm the use of SC (or other drugs), assessment has to be clinical, based on history where available, and recognising the clinical presentation

Chronic: psychosis, aggression

Treatment

Acute: symptom-directed supportive care, may require medication for agitation, convulsions, or psychosis

If symptoms are persistent or severe transfer to hospital may be necessary

Chronic: psychosocial and other appropriate support. Pharmacotherapy, where appropriate, for enduring symptoms

Depressants

Gamma
Hydroxybutyrate
(GBH) Class C

Gamma
Butyrolactone
(GBL) Class C

Street names
Gina Gamma-O
Blue Verve
Liquid E
Liquid Ecstasy

More
information
online

Desired effects

Euphoria, relaxation, increased sociability,
increased libido, sexual disinhibition

Adverse effects

Acute: overdose – tolerance does not necessarily confer protection and the risk of coma or death will be increased if taken with other depressant drugs such as alcohol or benzodiazepines. Other acute effects include drowsiness, cardiac, respiratory and gastrointestinal symptoms, hypothermia

Chronic: severe dependence

Users/modes of use

Users: clubbers, especially popular with MSM (men who have sex with men), chemsex scene

Modes of use: usually orally, mixed with a drink due to its salty taste, occasionally snorted, rarely injected

Treatment

Acute: symptom-directed supportive care, especially respiratory support and airway protection. Symptoms are usually short-lived, but if severe or persistent, transfer to hospital may be necessary

Chronic: motivational interviewing, relapse prevention, psychosocial support. Benzodiazepines and baclofen may be used to treat withdrawal symptoms. Acute withdrawal symptoms may be a medical emergency, requiring treatment with barbiturates

Depressants/dissociative

Ketamine Class B

Street names

Ket
Special K
Kit-Kat, Super K
Cornflakes

**More
information
online**

Desired effects

Dissociation, intense detachment (k-hole), perceptual disorders, auditory and visual hallucinations

Users/modes of use

Users: young (20-24), single, unemployed, students clubbers, MSM (men who have sex with men), polydrug users

Modes of use: snorted, rarely orally or injected

Adverse effects

Acute: nausea, slurred speech, dizziness, collapse, accidental injury, agitation, tachycardia, visual hallucinations

In the absence of rapid urine or blood tests to confirm the use of ketamine (or other drugs), assessment has to be clinical, based on history, where available, and recognising the clinical presentation

Chronic: ulcerative cystitis, k-cramps, psychosis, dependence

Treatment

Acute: symptom-directed supportive care until symptoms, which are usually short lived, resolve

Chronic: motivational interviewing, relapse prevention, psychosocial support, bladder monitoring, pain management, psychosocial support

Stimulants

Mephedrone Class B

Street names

Bubbles(s)
Miaow
Meow-Meow
Mcat
Top Cat
Mad-dog Roxy

More
information
online

Desired effects

“The ego of cocaine and loved-up feeling of ecstasy”, euphoria, elevated mood, reduced hostility, increased sensuality, improved sexual functioning, prolonged sexual performance

Adverse effects

Acute: psychosis, jaw clenching, teeth grinding, tremor, tachycardia, headache, convulsions

In the absence of rapid urine or blood tests to confirm the use of mephedrone (or other drugs), assessment has to be clinical, based on history, where available, and recognising the clinical presentation

Chronic: psychosis, depression, anxiety, cognitive impairment, dependence

Users/modes of use

Users: clubbers (especially gay clubbers), polydrug users adding to existing drug repertoire – rationale for polydrug use may be quite sophisticated

Modes of use: snorted, can irritate nose and cause nosebleeds. Swallowed (usually in a drink or bombed due to its bad taste), injected

Treatment

Acute: symptom-directed supportive care, managing agitation, convulsions, hypotension, hypertension and rhabdomyolysis in particular

If symptoms are severe or persistent, transfer to hospital may be necessary

Chronic: motivational Interviewing, relapse prevention, psychosocial support, treat any co-morbid conditions, anti-psychotics

Stimulants

**Ecstasy
(MDMA) Class A**

**Variants
(PMA/PMMA)
Class A**

Street names

**E, Molly
Mandy
MD**

**More
information
online**

Desired effects

Energy, euphoria, empathy, “loved up”

Adverse effects

Acute: hyperthermia, hyponatraemia (women especially), tachycardia, hypertension, serotonin syndrome, collapse, convulsions, hallucinations, headache, sweating, kidney injury, delayed orgasm, erectile dysfunction

In the absence of rapid urine or blood tests to confirm the use of ecstasy (or other drugs), assesment has to be clinical, based on history, where available, and recognising the clinical presentation

Chronic: cognitive impairment, neurotoxicity, depression, increased suicide risk

Users/modes of use

Users: clubbers, young people, students, polydrug users, 95% of time taken with alcohol

Modes of use: bombing crystals or powder is most common; also swallowed in tablet form and, rarely, dabbed

Treatment

Acute: symptom-directed supportive care while awaiting transfer to hospital for more specific treatment, such as cooling, management of dehydration and hyponatraemia

Chronic: psychosocial support, symptomatic support

Avoid monoamine oxidase inhibitors and selective serotonin reuptake inhibitors

Hallucinogens

Lysergamides (Class A)

Street names

LSD, Acid, A tab, Blotter,
Geltabs, Windowpane

Tryptamines (Class A)

Street names

Magic mushrooms,
Mushies, Shrooms

Phenethylamines (Class A)

Street names

Mescaline-Peyote, San
Pedro, Peruvian Torch, Bees,
Nexus, N-Bomb

More
information
online

Desired effects

Euphoria, mild stimulation, altered sense of time and space, enhanced appreciation of music, visual distortions, intensified sensual or sexual feelings

Adverse effects

Acute: dysphoria, panic, paranoia, tremor, tachycardia, tremor, hyperthermia, depersonalisation

In the absence of rapid urine or blood tests to confirm the use of hallucinogens (or other drugs), assessment has to be clinical, based on history, where available, and recognising the clinical presentation

Chronic: dependence (rare), flashbacks, persisting perceptual disorder

Users/modes of use

Users: young (16-24), polydrug users, used relatively infrequently

Modes of use: orally, sublingually, buccal, rarely snorted

Treatment

Acute: symptom-directed supportive care until symptoms (usually mild and transient) have resolved

Chronic: supportive-dependence is rare

References and further reading

References and further reading

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Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health

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